

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/17/2014
NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS		STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This survey was for the Investigation of Complaint IN00155437.</p> <p>Complaint IN00155437 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: September 16 & 17, 2014</p> <p>Facility number: 000104 Provider number: 155197 AIM number: 100266590</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF: 10 SNF/NF: 58 Residential: 117 Total: 185</p> <p>Census payor type: Medicare: 16 Medicaid: 54 Other: 115 Total: 185</p> <p>Sample: 3</p> <p>Sanctuary at St Pauls was found to be in compliance with 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00155437.</p> <p>Quality Review 09/17/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE